Top 10 Myths about Telepsychiatry

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by Donna Vanderpool, JD

The technology for remote treatment is advancing rapidly. The regulatory environment in which psychiatrists practice telepsychiatry is also evolving but at a much slower pace than the technology. As introduced in this journal years ago by my colleague Charles D. Cash in his article, "Telepsychiatry and Risk Management,"[1] there is still a lack of uniformity in how—and even whether—states address telemedicine requirements. This discrepancy has resulted in many myths around this topic. Fortunately, we are starting to see some concepts evolving that are generally consistent, regardless of the state, allowing us to clear up some prevalent misunderstandings about telepsychiatry.

MYTH #1

Services are deemed to be rendered where the psychiatrist is located.

Reality. All states are clear that a healthcare provider's services are rendered where the patient is physically located at the time of treatment. This fact has several implications, including the following:

1. If the patient is in a different state than the provider, and the provider is not licensed in the patient's state, the patient's state licensing board should be contacted to determine whether licensure in the patient's state is required. While almost all states require some type of licensure or registration, the issue seems to be fact-specific (see Myth #2). Note that providers do not want to be found practicing without a license, as that could have criminal and medical malpractice insurance implications.
2. The provider will need to comply with all relevant laws not only in his or her own state (establishing a treatment relationship, prescribing requirements, duty to warn, etc.) but also in the patient's state.
3. Providers need to confirm that their malpractice insurance covers them and will defend them in actions brought in the patient's state, if different from their state.

MYTH #2

State licensing boards are not responsive to questions about licensure requirements for telemedicine.

Reality. Actually, state licensing boards tend to be extremely responsive to telemedicine providers' inquiries regarding licensure requirements. In one case, the board representative advised the psychiatrist of a very narrow exception to the licensure requirements that he felt applied to the facts as presented by the inquiring out-of-state psychiatrist.

MYTH #3

In terms of state licensure requirements, you can rely on the state requirements indicated by the telemedicine company.

Reality. Licensing boards have made it clear that providers need to check with the board directly instead of relying on representations about licensure made by others. In one case,[2] an appellate court, in upholding the licensing board's suspension of a physician who had been disciplined for practicing without a license by treating a patient via telemedicine in another state, specifically criticized the physician for failing to contact the board to seek guidance on whether he could do what he wanted to do. While the physician had sought the opinion of an attorney employed by the telemedicine company who advised that no additional licensure was required, the court felt that the physician should not have relied upon the attorney and should himself have contacted the licensing board.

MYTH #4

Telephone treatment is not telemedicine.

Reality. Treatment by telephone might or might not be within a specific state's definition of telemedicine. For example, the Medical Board of California specifies that "telehealth is not a telephone conversation…"[3] By contrast, Ohio law states "…the practice of telemedicine means the practice of medicine in this state through the use of any communication, including oral, written, or electronic communication, by a physician located outside of this state."[4]

Even if telephone treatment is not technically defined to be telemedicine by a particular state, it might still be deemed to be the practice of medicine. Thus, all of the telemedicine issues are still relevant, including licensure and standard of care.

MYTH #5

There is a different standard of care for the remote treatment of patients than for patients seen in-person.

Reality. All states that have addressed the issue are consistent in saying that the standard of care for telemedicine is the same as the standard of care for patients seen in-person. The following are examples:

1. From the Medical Board of California: "The standard of care is the same whether the patent is seen in-person, through telemedicine or other methods of electronically enable health care…In summary, the law governs the practice of medicine and no matter how communication is performed, the standards are no more or less… Physicians practicing via telemedicine are held to the same standard of care, and retain the same responsibilities of providing informed consent, ensuring the privacy of medical information, and any other duties associated with practicing medicine."[3]
2. From the Maryland Medical Board: "The Board shall use the same standards in evaluating and investigating a complaint and disciplining a licensee who practices telemedicine as it would use for a licensee who does not use telemedicine in the licensee's practice."[5]

MYTH #6

It is OK to treat patients via free Skype.

Reality. If you use a system wherein patient-identifying information is created, received, maintained, or transmitted, you must have in place a Business Associate Agreement (BAA) with the system vendor. The BAA documents the third party's promises to protect your patients' protected health information. For those using free Skype, Microsoft currently will not provide a BAA. For providers who are covered entities under HIPAA, failure to have a BAA violates HIPAA's Privacy Rule, might violate state confidentiality law, and also violates the provider's ethical obligations to protect patient confidentiality. For those not technically covered under HIPAA, the Privacy and Security Rules have been seen by the court as indicators of the standard of care[6] and could be used against the provider in an action under state law or administrative action.

Case example:[7] A psychiatrist was disciplined by his licensing board after it received three complaints stemming from his telepsychiatry practice. Two complaints related to his prescribing practices, and another, from the state Medicaid program, alleged that he was treating Medicaid patients via telemedicine using Skype, which was not a Medicaid-approved network. The Medicaid complaint also alleged that he had prescribed controlled substances without an in-person evaluation and that he had failed to get patients' consent for the use of telemedicine. The state Medicaid program provided for reimbursement of telemedicine visits if, among other things, HIPAA and state privacy requirements were maintained and followed at all times, and the network used was on the list of Medicaid-approved telemedicine networks. Additionally, the medical board had a telemedicine policy that required the use of a telemedicine network that met all technical and confidentiality standards as required by state and federal law, as well as the patient's written consent to participate in telemedicine. The psychiatrist was disciplined for nine counts of unprofessional conduct; however, these did not include the inappropriate use of technology. Subsequently, the medical board issued rules explicitly requiring that web-based video meet the equipment requirements; if those equipment requirements are not met, an actual face-to-face encounter between physician and patient would be required.[8]

MYTH #7

Telemedicine providers never need to see the patient in-person.

Reality. This is not necessarily true. Historically, states tended to require an in-person physical examination as a prerequisite to a valid physician-patient relationship. While the recent trend has been to move away from the in-person visit requirement where the technology used is sufficient to allow a physician the same ability to evaluate a patient that he or she would have in-person,[9] there are many circumstances where it is still required, such as when prescribing controlled substances.

MYTH #8

Prescribing via telepsychiatry is the same as prescribing when seeing a patient in-person.

Reality. Actually, there are stringent requirements for prescribing controlled substances via telepsychiatry. The federal Controlled Substance Act was amended by the Ryan Haight Act to require at least one in-person visit prior to prescribing controlled substances, with extremely limited exceptions. Some states' laws are consistent with federal law. For example, the Rhode Island medical board is clear and "specifically highlights that prescribing

controlled substances without an established in-person physician-patient relationship is prohibited."[10] Some states do not address it. In Florida, the medical board prohibited prescribing controlled substances, then decided to allow it, but only for the treatment of psychiatric disorders.[11]

MYTH #9

Treating out-of-state college students is not telemedicine.

Reality. This might or might not be true. Psychiatrists treating out of state remotely, whether while the patient is away at college or spending the summer in Florida, might be considered as practicing telemedicine and could be expected to be in compliance with all licensure and other requirements. The licensing board in the patient's state is the entity to determine whether licensure in the patient's state is required, given the specific facts.

MYTH #10

Treating via telemedicine provides you the same abilities to examine the patient that you would have in an in-person visit.

Reality. Even with great advances in technology, this is not true. When providing care via telepsychiatry, you must be cognizant of the problems of lost abilities—in other words, the inability to use (or fully use) certain senses to examine the patient. For example, if you are treating a patient with alcohol abuse issues, being able to smell the patient's breath might be important. Less easy to articulate is the sixth sense that most psychiatrists have regarding their patients that lets them know immediately if a patient is not doing well. This ability is often lost in telemedicine. All of this becomes very important, because as previously stated, the standard of care does not change when you are treating a patient remotely. You are expected to be able to render the exact same level of care you would provide if the patient was in your office.

REFERENCES

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3. Medical Board of California. Practicing Medicine Through Telehealth Technology. http://www.mbc.ca.gov/Licensees/Telehealth.aspx.
4. Ohio Rev. Code Ann. § 4731.296(A) (West 2015).
5. Md. Admin. Code §10.32.05.07 (2017).
6. E.g., Emily Byrne v. Avery Center For Obstetrics and Gynecology, P.C., 2014 WL 5507439 (Conn. Super. Ct. 2014) and Acosta v. Byrum, 180 N.C.App. 562 (N.C. Ct. App. 2006).
7. The Oklahoma State Board of Medical Licensure and Supervision v. Thomas Edward Trow, M.D., State Board of Medical Licensure & Supervision. No. 11-11-4439 (Sept. 12, 2013).
8. Okla. Admin. Code § 435:10-1-4 (Jan. 16, 2014).
9. American Medical Association. 50-state survey: Establishment of a patient-physician relationship via telemedicine (2007). https://www.ama-assn.org/sites/default/files/media-browser/specialty%20group/arc/ama-chart-telemedicine-patient-physician-relationship.pdf. Note that this resource[9] should not be relied upon as currently accurate. Laws can and do change frequently, particularly those addressing telemedicine. As an example, Texas law has been amended to allow for treatment to be established without an in-person visit as long as specified conditions are met.
10. Rhode Island Board of Medical Licensure and Discipline. Guidelines for Appropriate Use of Telemedicine and the Internet in Medical Practice. http://www.health.ri.gov/publications/guidelines/provider/AppropriateUseOfTelemedicineAndTheInternetInMedicalPractice.pdf.
11. Fla. Admin. Code § 64B8-9.0141 (2016).

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